Unique Administrative Functions

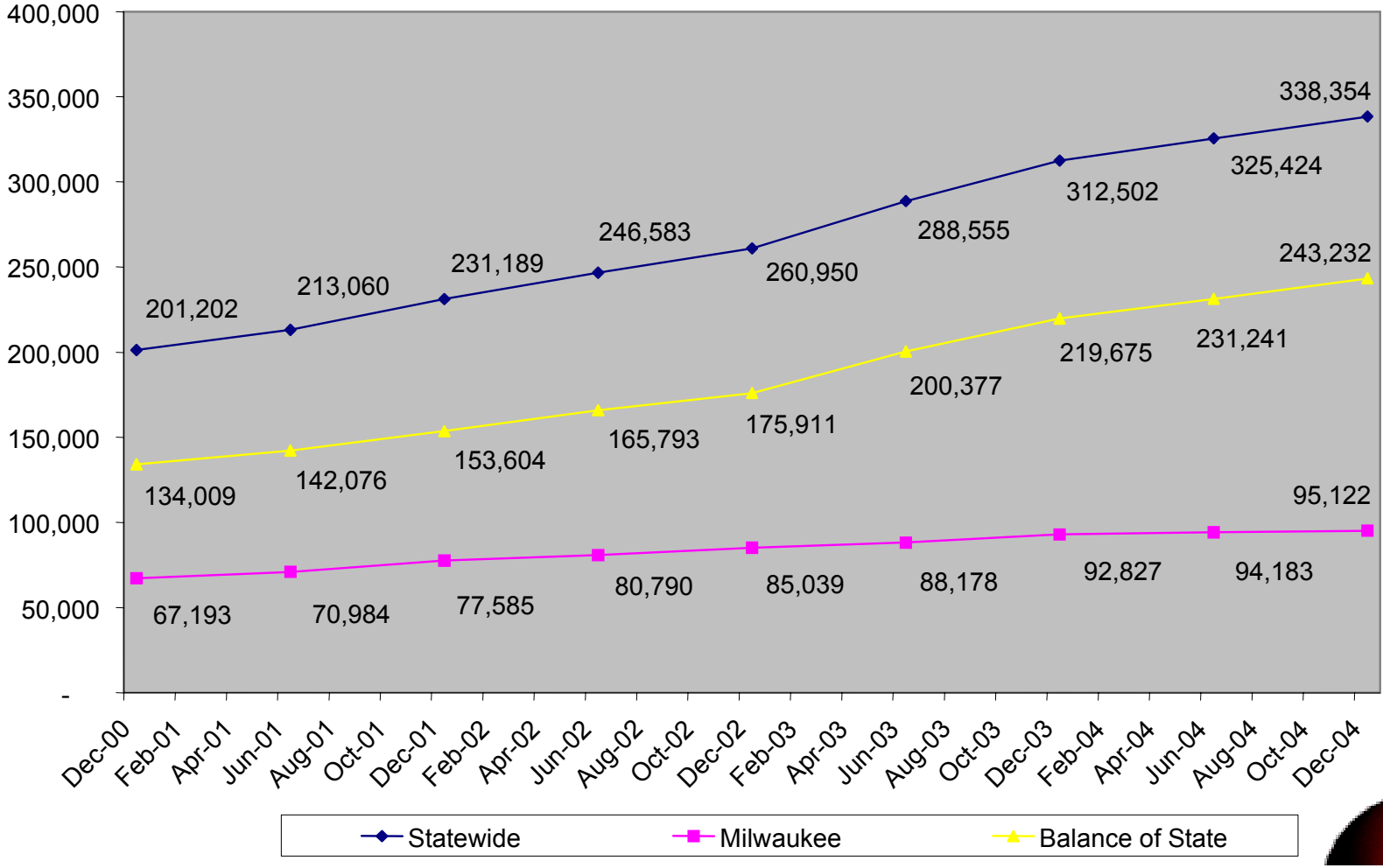
Unique Administrative Functions

- Eligibility determination / economic underwriting
- Program integrity
- Pharmacy benefits management
- HMO contracting and rate setting
- Federal reporting
- Fiscal oversight
- Cost allocation

Eligibility Determination

- With the exception of persons with SSI, foster care, Katie Beckett and SeniorCare, eligibility for Medicaid is determined by county and tribal income maintenance (IM) agencies.
- DHFS is required by statute to contract with County human/social services agencies to administer IM programs.
- Federal law requires that eligibility determination be done by public workers.
- IM administration is optional for tribal agencies and 7 have chosen to participate.
- Historically, funding for local IM has not kept pace with rising caseloads. From Dec. 2000 to Jan. 2005, IM caseloads have increased 70%, from 201,200 to 341,600.

Income Maintenance Caseloads (CC, FS, MA/BC & W2)



Eligibility Determination Application Process

- To apply for benefits, an individual must fill out and mail a paper application or apply in person at a local IM agency and go through an automated, interactive interview with a case worker.
- Caseworkers verify mandatory and questionable information.
- Individuals eligible for BadgerCare who are employed must comply with employment and insurance verification requirements.

Eligibility Determination Application Process

- The Medicaid and BadgerCare eligibility information is verified against other automated databases, including Social Security, state wage information, unemployment compensation and KIDS (child support payments).
- Data received from Social Security updates the CARES system and eligibility is redetermined automatically. Data from other sources must be verified by eligibility workers who manually redetermine eligibility.

Eligibility Determination Changes

- For Medicaid and BadgerCare, recipients are required to report any changes that could affect eligibility and benefits, such as income, household composition and address, within 10 days.
- BadgerCare recipients who obtain new employment must also comply with employment and insurance verification requirements.

Eligibility Determination Review

- Once per year, all recipients must have their continuing Medicaid eligibility redetermined, which can be done by mailing in a paper review form or in-person with a case worker.
- BadgerCare recipients must again comply with the insurance and employment verification requirements at least once every 12 months.

Eligibility Determination - CARES

- The Client Assistance for Reemployment and Economic Support (CARES) system is an automated, public assistance eligibility and case management system.
- CARES supports the income maintenance (IM) and employment program operations of DWD and DHFS.
- CARES is used by county and tribal IM agencies, W-2 agencies (private and public) and state staff to determine and track eligibility for Medicaid, BadgerCare, SeniorCare, FoodShare, the SSI caretaker supplement (CTS), W-2 and child care programs.

Eligibility Determination - CARES

- CARES interfaces with other systems that issue benefits and handle on-going benefits management functions, such as the MMIS (Medicaid and CTS) and EBT (FoodShare).
- CARES is a system that must continually be reinvented as programs are reengineered (i.e., AFDC to W-2), new programs are added (BadgerCare, MAPP, CTS, SeniorCare) and new system needs arise (reducing workload through new user interface).

Program Integrity

- DHCF completed 2,100 provider audits in SFY 2004.
- The audits seek to verify that the services were provided and that the provider complied with all Medicaid requirements, including medical necessity and proper documentation.
- Audits will save Medicaid $14 million in SFY 2005.
- A recent CMS review of the DHCF program integrity unit found that the overall detection and prevention of Medicaid fraud and abuse were “impressive”.
- DHFS promoted increased efficiency by automating auditor worksheets, documentation and reports, and developing sophisticated means for extracting relevant claims information from the MMIS that auditors can use onsite.

Program Integrity

- The DHCF program integrity unit collaborates with the Wisconsin Department of Justice and other law enforcement agencies to refer, investigate and prosecute Medicaid fraud.
- The Medicaid Fraud Control Unit, part of the Department of Justice, investigates and prosecutes crimes committed against vulnerable adults in nursing homes and other facilities that receive Medicaid funding, as well as fraud perpetrated by providers against the Wisconsin Medicaid program.

Pharmacy Benefits Management

- The management of the Medicaid pharmacy benefit involves multiple processes:
  - Calculation of reimbursement and dispensing fees
  - Point-of-Service, online claims processing
  - Drug utilization review (DUR)
  - Prior authorization
  - Copays
  - Brand medically necessary policies
  - Preferred drug list
  - Rebates and supplemental rebates.

Managed Care Contracting and Oversight

- The management of Medicaid managed care programs includes:
  - HMO contracting and network certification
  - HMO rate setting
  - Contracting with an independent managed care enrollment broker
  - Processing and resolving complaints and grievances
  - Performance measurements
  - Assuring HMO compliance with federal regulations
  - Other quality assurance activities

Managed Care Contracting and Oversight

- Mandatory Medicaid managed care programs are federally required to contract with an unbiased enrollment broker. Functions of the broker include:
  - Enrolling recipients in a participating HMO
  - Providing impartial information to enable recipients to make a well-informed HMO choice
  - Providing information and assisting recipients in completing forms for enrollment, disenrollment, exemption requests, grievances and appeals
  - Educating recipients on access to services
  - Conducting recipient health needs assessments at the time of enrollment

Federal Reporting Requirements

In order to receive federal matching funds, Medicaid must provide very detailed information on expenditures, utilization, payments and projections to CMS. Quarterly, DHFS files:

- The CMS-37, a two-year projection which details the State's Medicaid funding requirements for the upcoming quarter and certifies the availability of the requisite state and local funds.
- Following a review of the CMS-37, CMS issues a grant award authorizing federal funding for the certified quarter.

Federal Reporting Requirements

- The CMS-64 is the accounting statement which reconciles the monetary advance, based on the CMS-37 projection, to the actual expenditures for most recent quarter and for prior periods.
- The CMS-64 must include data on:
  - Total Title 19 expenditures
  - State Medicaid payments by service type
  - Adjustments to prior period payments made during the current quarter
  - Third-party liability collections
  - Drug rebates
  - Administrative spending
- DHFS provides CMS supporting documentation for the data each quarter.

Federal Reporting Requirements

- The CMS-21B is the two-year projection detailing the State's Title 21 requirements for the upcoming quarter.
- The CMS-21 is the State's accounting statement Title 21 fund expenditures for the most recent quarter and previous fiscal years, including recoupments, refunds and adjustments for premiums and cost sharing.
- Form CMS-21 presents actual expenditures for which the state is entitled to federal reimbursement; however, reconciliation of expenditures to estimates does not occur until after the period of availability for allotments has expired.
- Administrative costs for Title 21 programs may also be included on the CMS-21 if the state opts to claim federal reimbursement at the enhanced rate.
- Program costs for children covered under Title 21 are reported on the CMS-64.

Federal Reporting Requirements

- In addition to inclusion in the quarterly CMS-37, CMS-21b, CMS-21 and CMS-64 reports, there are reporting requirements specific to waivers:
  - 1115 demonstration waivers require budget neutrality justification and demonstration.
  - 1915 waivers require proof of cost effectiveness and/or cost neutrality.
  - Waivers often require more detailed or separate reporting of enrollment and program participation.
  - Many waivers require periodic analysis and reporting in addition to the budget neutrality demonstration.

Cost Allocation Plan

- A cost allocation plan (CAP) is both a narrative document and set of reports that show how costs are allocated to program areas, such as Medicaid, TANF, etc.
- State Medicaid agencies must have cost allocation plans approved by the federal Division of Cost Allocation (DCA) in conjunction with CMS.
- There are two federal documents, the OMB-A87 and ADMB C-10, that govern cost allocation.

Cost Allocation Plan

- Costs are allocated using a variety of statistics, including case counts, eligibility rates and time studies.
- Wisconsin has several cost allocation plans including:
  - DHFS Indirect cost allocation plan
  - DHFS public assistance cost allocation plan
  - Local agency cost allocation plans
  - MMIS cost allocation plan
- All of these plans may be used to allocate administrative or indirect costs to the Medicaid program.

External Oversight of Medicaid

- The Medicaid reimbursement and financial reporting systems are routinely reviewed by the Legislative Audit Bureau (LAB)
  - LAB conducts annual audits. Field work is conducted for 6 to 9 months each year.
  - LAB has not documented any questioned costs over the last several years.
  - An LAB audit of personal care providers in 2002 contained no material adverse findings. LAB noted that although DHCF is not required to meet government auditing standards, the Medicaid audit function has many of the program elements the standards call for.

External Oversight of Medicaid

- The Medicaid financial tracking and reporting systems are continually reviewed by CMS.
  - In addition to reviewing and approving quarterly expenditure, projection, waiver and state plan amendment submissions, CMS conducts more thorough reviews of specific programs and populations on a regular basis.

External Oversight of Medicaid

- Medicaid expenditures and reporting are reviewed and audited by other federal agencies, such as the Office of the Inspector General (OIG) and the General Accounting Office (GAO) and state agencies, such as the DHFS Office of Strategic Finance (OSF) Program Evaluation and Audit Section.
- Following a recent audit, OSF found that the Department's audit processes overall were rigorous but reasonable.
- A recent GAO report on state MA program integrity activities notes that Wisconsin's audit function was cited by national health care fraud and abuse experts and was particularly active in identifying and responding to improper payment issues.